CONFIDENTIAL

Iowa Department of Public Health

Infant Botulism

Agency:

Investigator:

Phone number:

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name:
First and middle name:
Maiden name: Suffix:
Address line:
Zip: City:
State: County:
Phone: ( )- - Type:
Long-term care resident: ☐ Yes ☐ No ☐ Unknown
Facility name:

Date of Birth: / / Estimated? ☐ Age:
Gender: ☐ Female ☐ Male ☐ Other
Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Unknown ☐ Hawaiian or Pacific Islander ☐ White
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Parent/Guardian name:
Parent/Guardian phone: ( )- - Type:

EVENT

Diagnosis date: / / Onset date: / /
Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown
Outbreak related: ☐ Yes ☐ No ☐ Unknown
Outbreak name:
Exposure setting:
Epi-linked: ☐ Yes ☐ No ☐ Unknown
Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown
State: Country:

Healthcare provider information

Last name:
First name:
Provider title: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA
Facility name:
Address line 1:
Address line 2:
Zip code: City:
State: County:
Phone : ( )- - Type:

LABORATORY FINDINGS

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: Toxin Type: ☐ A ☐ B ☐ Other

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: Toxin Type: ☐ A ☐ B ☐ E ☐ F ☐ Other

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: Toxin Type: ☐ A ☐ B ☐ E ☐ F ☐ Other

Child Care

Is the case attending a child care facility? ☐ Yes ☐ No ☐ Unknown
(If yes, complete the following sections for each known occupation. If No, skip to the next section.)

Date attend from: ___/___/___ Facility name: _____

Date attended to: ___/___/___ Address: _____

Zip code: _____

City: _____

Phone: (___)-___-___ Type:

Date attend from: ___/___/___ Facility name: _____

Date attended to: ___/___/___ Address: _____

Zip code: _____

City: _____ State: _____ County: _____

Phone: (___)-___-___ Type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: _____ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): _____

Admission date: ___/___/___ Discharge date: ___/___/___ Days hospitalized: _____

Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

OTHER DEMOGRAPHIC INFORMATION

Father's age in years: _____ Education: ☐ Grade school ☐ Middle school ☐ High school ☐ Vocational/trade school ☐ Associate's degree ☐ Bachelor's degree or higher

Occupation:
- ☐ ~~Student – child care/preschool~~
- ☐ Student-elementary thru high school
- ☐ Student-post high school, college, etc
- ☐ Child (0-18 yrs) not attending school/day care
- ☐ Child care provider/worker, other work with children
- ☐ Teacher/staff – preschool
- ☐ Teacher/staff – elementary/high school
- ☐ Teacher/staff – post high school, college, etc
- ☐ Healthcare worker/staff
- ☐ Resident – long term care facility
- ☐ Worker- farming
- ☐ Worker – manufacturing/industrial
- ☐ Worker – Sales/retail
- ☐ Worker – transportation
- ☐ Worker - business
- ☐ Worker – food service
- ☐ Worker – non manufacturing/service
- ☐ Worker - other
- ☐ Retired
- ☐ Works at home/stay at home parent
- ☐ Unemployed
- ☐ Other adult
- ☐ Unknown, adult (19 yrs or older)

Mother's age in years: _____ Education: ☐ Grade school ☐ Middle school ☐ High school ☐ Vocational/trade school ☐ Associate's degree ☐ Bachelor's degree or higher

Occupation:
- ☐ ~~Student – child care/preschool~~
- ☐ Student-elementary thru high school
- ☐ Student-post high school, college, etc
- ☐ Child (0-18 yrs) not attending school/day care
- ☐ Child care provider/worker, other work with children
- ☐ Teacher/staff – preschool
- ☐ Teacher/staff – elementary/high school
- ☐ Teacher/staff – post high school, college, etc
- ☐ Healthcare worker/staff
- ☐ Resident – long term care facility
- ☐ Worker- farming
- ☐ Worker – manufacturing/industrial
- ☐ Worker – Sales/retail
- ☐ Worker – transportation
- ☐ Worker - business
- ☐ Worker – food service
- ☐ Worker – non manufacturing/service
- ☐ Worker - other
- ☐ Retired
- ☐ Works at home/stay at home parent
- ☐ Unemployed
- ☐ Other adult
- ☐ Unknown, adult (19 yrs or older)

Number of pregnancies: Number of live births:

For this birth:

Delivery type: ☐ C-section ☐ Vaginal Complications: ☐ Yes ☐ No ☐ Unknown

Describe complications: _____

Premature? ☐ Yes ☐ No ☐ Unknown Gestational age in weeks: _____ Birth weight/units: _____ Unit: ☐ Pounds/ounces ☐ Kilograms ☐ Grams

CLINICAL INFO & DIAGNOSIS

Interviewee: ☐ Father ☐ Mother ☐ Both ☐ Other _____

For the period from birth to the onset of symptoms:

Fever (>101°F) ☐ Yes ☐ No ☐ Unknown Onset Date: ___/___/___ Describe frequency: _____

Highest known fever: _____ °C or °F Date of highest fever: ___/___/___

Cold ☐ Yes ☐ No ☐ Unknown Onset Date: ___/___/___ Describe frequency: _____

Constipation ☐ Yes ☐ No ☐ Unknown Onset Date: ___/___/___ Describe frequency: _____

Diarrhea ☐ Yes ☐ No ☐ Unknown Onset Date: ___/___/___ Describe frequency: _____

Frequency of bowel movements: ☐ 2 or more per day ☐ Every other day ☐ 1 per week ☐ 1 per day ☐ 2-3 times per week ☐ Less than 1 per week

For the period after the onset of symptoms:

Constipation: Onset Date: ___/___/___

Poor eating: Onset Date: ___/___/___

Altered cry: Onset Date: ___/___/___

Poor head control: Onset Date: ___/___/___

General weakness: Onset Date: ___/___/___

First Symptom: ☐ Altered cry ☐ Cold ☐ Constipation ☐ Diarrhea ☐ Fever ☐ General weakness ☐ Poor feeding ☐ Poor head control

Second Symptom: ☐ Altered cry ☐ Cold ☐ Constipation ☐ Diarrhea ☐ Fever ☐ General weakness ☐ Poor feeding ☐ Poor head control

Bowel movement frequency: ☐ 2 or more per day ☐ 1 per day ☐ Every other day ☐ 2-3 times per week ☐ 1 per week ☐ Less than 1 per week

Health care provider visited? ☐ Yes ☐ No ☐ Unknown

Dates visited: ___/___/___, ___/___/___

Facility name: _____

Address line 1: _____

Address line 2: _____

Zip code: _____

State: _____ City:

Phone : ( )- - County:

Last name: Type:

First name:

Provider title: ☐ ARNP ☐ DO

Spinal tap performed? ☐ Yes ☐ No ☐ Unknown

Date: ___/___/___

Normal: ☐ Yes ☐ No ☐ Unk

Spinal fluid protein: ☐ in (unit of measure) ☐ mg/dL ☐ g/L ☐ µmol/L

Spinal fluid glucose: ☐ in (unit of measure) ☐ mg/dL ☐ µmol/L

WBC count: ☐ in (unit of measure) ☐ cells / mm3 ☐ cells/mL

OTHER LAB FINDINGS

Food, medication or environmental samples tested? ☐ Yes ☐ No ☐ Unknown

(If Yes, complete the following section. If No, then skip to the next section.)

Tested for preformed toxin: ☐ Yes ☐ No ☐ Unk Laboratory: _____ Toxin type: ☐ A ☐ B ☐ E ☐ F ☐ G

Describe samples: _____ List positive samples: _____

Tested for C. botulinum or other serotype: ☐ Yes ☐ No ☐ Unk Laboratory: _____

Describe samples: _____ List positive samples: _____

TREATMENT

For the illness, were any of the following treatments required:

Oxygen: ☐ Yes ☐ No ☐ Unk **Ventilator:** ☐ Yes ☐ No ☐ Unk Duration in days: _____

Tracheotomy: ☐ Yes ☐ No ☐ Unk **Intubation:** ☐ Yes ☐ No ☐ Unk Duration in days: _____

Feeding tube: ☐ Yes ☐ No ☐ Unk Duration in days:

Botulism immune globulin (BIG) prescribed? ☐ Yes ☐ No ☐ Unk **Therapeutic medications prescribed?** ☐ Yes ☐ No ☐ Unk

Date started: _____ List medications: _____

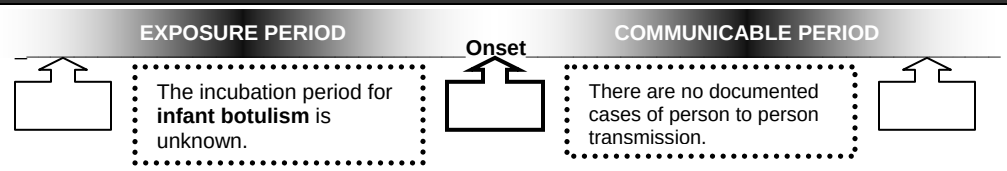
Dose: _____ Unit: _____

Number of days: _____ Number of times each day: _____

Route: _____

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

Primary feeding method: ☐ Breastfed exclusively ☐ Predominantly breastfed ☐ Both equally ☐ Formula fed exclusively ☐ Predominantly formula fed

Pacifier use: ☐ Yes ☐ No ☐ Unk Frequency: ☐ Often ☐ Sometimes ☐ Rarely

Pacifier dipped in substance: ☐ Yes ☐ No ☐ Unk Substance: ☐ Honey ☐ Syrup

Environmental change or disruption prior to onset: ☐ Yes ☐ No ☐ Unk

Describe environmental change/disruption: _____

Gardening work near infant prior to onset: ☐ Yes ☐ No ☐ Unk

Describe work: _____

Infant away from home more than 1 week prior to onset: ☐ Yes ☐ No ☐ Unk

Describe circumstances: _____

Dietary Information – *in the time period from birth to onset of symptoms:*

Infant formula: ☐ Yes ☐ No ☐ Unknown

Frequency: ☐ Once/few times ☐ Many times ☐ Daily/most days

Formula brand: ☐ Enfamil ☐ Good start ☐ Similac ☐ Store brand ☐ Other _____

Ready to eat formula: ☐ Yes ☐ No ☐ Unk

Cow's milk: ☐ Yes ☐ No ☐ Unknown

Frequency: ☐ Once/few times ☐ Many times ☐ Daily/most days Source/type: _____ Brand name: _____

Cow's milk products (cheese, whip cream, etc.): ☐ Yes ☐ No ☐ Unknown

Frequency: ☐ Once/few times ☐ Many times ☐ Daily/most days Source/type: _____ Brand name: _____

Fruit juice: ☐ Yes ☐ No ☐ Unknown

Frequency: ☐ Once/few times ☐ Many times ☐ Daily/most days Source/type: _____ Brand name: _____

Cereal: ☐ Yes ☐ No ☐ Unknown

Frequency: ☐ Once/few times ☐ Many times ☐ Daily/most days Source/type: _____ Brand name: _____

Bread: ☐ Yes ☐ No ☐ Unknown

Frequency: ☐ Once/few times ☐ Many times ☐ Daily/most days Source/type: _____ Brand name: _____

Syrup: ☐ Yes ☐ No ☐ Unknown
Frequency: ☐ Once/few times ☐ Many times ☐ Daily/most days Source/type: _____ Brand name: _____

Honey: ☐ Yes ☐ No ☐ Unknown
Frequency: ☐ Once/few times ☐ Many times ☐ Daily/most days Source/type: _____ Brand name: _____

Sugar: ☐ Yes ☐ No ☐ Unknown
Frequency: ☐ Once/few times ☐ Many times ☐ Daily/most days Source/type: _____ Brand name: _____

Tea: ☐ Yes ☐ No ☐ Unknown
Frequency: ☐ Once/few times ☐ Many times ☐ Daily/most days Source/type: _____ Brand name: _____

Cooked fruits: ☐ Yes ☐ No ☐ Unknown
Frequency: ☐ Once/few times ☐ Many times ☐ Daily/most days Source/type: _____ Brand name: _____

Raw fruits: ☐ Yes ☐ No ☐ Unknown
Frequency: ☐ Once/few times ☐ Many times ☐ Daily/most days Source/type: _____ Brand name: _____

Cooked vegetables: ☐ Yes ☐ No ☐ Unknown
Frequency: ☐ Once/few times ☐ Many times ☐ Daily/most days Source/type: _____ Brand name: _____

Raw vegetables: ☐ Yes ☐ No ☐ Unknown
Frequency: ☐ Once/few times ☐ Many times ☐ Daily/most days Source/type: _____ Brand name: _____

Home canned food: ☐ Yes ☐ No ☐ Unknown
Frequency: ☐ Once/few times ☐ Many times ☐ Daily/most days Source/type: _____ Brand name: _____

Baby food: ☐ Yes ☐ No ☐ Unknown
Frequency: ☐ Once/few times ☐ Many times ☐ Daily/most days Source/type: _____ Brand name: _____

NOTES: _____